2018 Open Enrollment Interactive Benefits Guide: Captioning Documents (Transcripts)
For COBRA Participants

Important: The following document provides the captioning (scripts) of the audio presented in the online Open Enrollment Interactive Benefits Guide. To view the online guide, visit de.gov/statewidebenefits (Select the "Open Enrollment" button, then choose your group).

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Welcome

Welcome to the Open Enrollment Interactive Benefits Guide. The guide uses audio, screen interaction and navigation demos of the Statewide Benefits Office (SBO) website to help users learn about the benefits they are eligible for through the State of Delaware. The guide was created to assist you in being a wise health care consumer when selecting the benefit plans that best meet the needs of you and your family during Open Enrollment.

Navigation

In order to ease your user experience in this guide, we will first review some of the most important navigation tips. If you would like to skip this navigation information, feel free to select the Main Menu link in the Navigation Panel on the left to access the content of the guide.

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Once the navigation demonstration ends, you will be able to view the Main Menu. From this Main Menu, you will need to select the group that you belong to by clicking on one of the following headers:

- Active State Employees
- State Non-Medicare Pensioners
- State Medicare Pensioners
- Participating Group Employees
- COBRA Participants

Under the header, there is a brief description of the members that belong in the group and a button to access the section of the guide that applies to members of that group. Once you have clicked the button, the "What's New" page for your selected group will appear. From this page, you can access the Menu button on the top left side of the screen. You can use this Menu button to navigate to all of the benefit information that applies to the group you selected. Notice that the header for any of the screens under the Menu button provides the name for the group that you selected.

Once you have selected an option from the Menu button, audio will begin and information will be displayed on the screen. There are several buttons that will allow you to control what you are viewing and hearing on the screen:

- If you need to, you can view the captioning for the screen that you are viewing by selecting the Closed Caption icon.
- The volume button can be used to adjust the volume of the audio or you can use the volume button for your computer or device.
- You can play or pause the information by clicking this button.
- If you want to rewind or fast forward the content, click and drag the progress bar. If you drag it to the left you can rewind the material on the screen and dragging it to the right will fast forward the material.
- If you want to restart the information for the screen that you are viewing, click this button.

Once the progress bar reaches the end for the screen you are viewing, you can learn additional information about the topic by clicking any links that appear on the screen. These links will take you to the SBO website in order to access additional information. If you choose to use the link, the website will open in a separate window - this way you can close that window when you are done browsing the website and easily return to the guide. If you do not want to use the link on the screen, you can use the Menu button to view additional information for your group.

Another helpful feature is the Resource menu. If you click Resources, you will notice a few web links that allow you to navigate to additional benefit information. There are also takeaway documents for each of the groups that provide the highlights of the information in this interactive guide.

The Navigation menu at the top of the screen can be used to quickly navigate through the course. You can simply click the link for the Main Menu or the "What's New" page for any of the groups to navigate to that page. Remember, once you are on the "What's New" page for any group, you can use the Menu button at the top of the screen to view information that is applicable to your group.

There is also a Glossary tab to the left that provides the definition for various benefit-related terms. You can access the Glossary at any time while using this guide.

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When you are done viewing the information in this guide, simply close the viewing window. The link to the guide will remain on SBO's website throughout the Open Enrollment period if you ever want to view it again.

Main Menu

Benefits Open Enrollment for COBRA participants is May 7 - 25, 2018:
COBRA Participants are individuals who were previously covered as an employee or dependent in the State of Delaware Group Health Insurance Program (GHIP) and are currently receiving COBRA benefits.

What's New

Each year, benefit-eligible employees and pensioners are given an important opportunity during Open Enrollment to review and make changes to their benefit elections for the upcoming plan year. The 2018 Benefits Open Enrollment period is for the plan year beginning July 1, 2018, and is your once-a-year chance to enroll or cancel coverage; to change plans, and add or drop coverage for your eligible spouse and dependent children.

The State of Delaware wants you to take action this May to make sure you are enrolled in the benefit plans that provide the ***BEST VALUE*** for you and your family! Getting the ***BEST VALUE*** means reviewing your benefit options (what do the plans offer, what providers are in the plan's network and how much will services cost?) and making informed decisions about what plans are most affordable and aligned with your needs. Making informed decisions regarding your benefit plan selections is an important step towards helping the State of Delaware to control rising health care costs and to maintain high quality, affordable options. The benefit plan premiums (or rates) for the health, dental and vision plans will not change on July 1, 2018. However, there are a number of health benefit design changes intended to help you obtain the same level of quality and service at reduced costs to you and the State of Delaware.

Here is *What's New* during this year's Open Enrollment:

- Laboratory and imaging services cost less at non-hospital affiliated freestanding facilities, offer great quality and convenient locations, operating hours and scheduling. Beginning July 1, 2018, copays for basic and high-tech imaging and lab services under the Aetna HMO and Highmark Delaware Comprehensive PPO plans will be changing. View the cost comparisons on the screen. Members enrolled in these plans who utilize the preferred site-of-care for basic and high-tech imaging and lab services will pay the lowest copay or even nothing out of pocket for services such as X-rays, ultrasounds, mammography and MRIs. So, when your doctor orders outpatient lab and imaging services, you can save both time and money by choosing the preferred site-of-care: non-hospital affiliated freestanding facilities.

- Aetna and Highmark Delaware have designated certain health care facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities, sometimes referred to as Blue Distinction Centers, Institutes of Quality or Institutes of Excellence, have been identified as delivering high quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions. Beginning July 1, 2018, members having orthopedic (such as knee or hip replacement surgery) and spine procedures (such as a spinal fusion or laminectomy) under the Aetna HMO and Highmark Delaware Comprehensive PPO plans will have the lowest copay when performed at a COE Facility. View the cost comparisons on the

screen. Get the quality of care you and your family deserve! Choose a COE Facility for your orthopedic and spine services.

- There are additions to preventive care covered at 100%. Beginning July 1, 2018 under the Aetna or Highmark non-Medicare health plans:

    - Annual mammography for women ages 40 and older, including 3-D
    - Generic low to moderate dose statins (for preventive and non-preventive use) will be covered for members 40 to 75 years of age through the Express Scripts Prescription Drug Plan. Statins are a class of drugs that lower the level of cholesterol in the blood, which can help prevent heart attacks and strokes.

  Check your plan for complete details and prior authorizations on preventive care covered at 100%. Preventive care is one of the most important ways to keep you and your family healthy.

- The State of Delaware Spousal Coordination of Benefits Policy has been modified to include ***additional*** situations where a spouse MUST enroll in their employer coverage. Benefit-eligible active employees and non-Medicare pensioners who will cover a spouse in one of the State of Delaware's Group Health Insurance plans MUST fully comply with the Spousal Coordination of Benefits Policy. This includes the requirement to complete a Spousal Coordination of Benefits form during the Open Enrollment period. The form is used to determine a spouse's eligibility to receive primary coverage in a State of Delaware Group Health Insurance plan and to certify if the spouse has other health care coverage available through his or her employer or former employer. Information on the Spousal Coordination of Benefits Policy including an informational video and a chart with examples are available on the SBO website.

Now that you have learned what's new, be an engaged consumer and actively participate in this year's Open Enrollment process by following the ***VALUE FIVE*** **Call To Action** steps noted on the screen. When you are finished reviewing the Call To Action steps, click "Continue."

Enrollment Action Checklist

The Statewide Benefits Office created an Open Enrollment Action Checklist to help you navigate the Open Enrollment process and understand what to do in order to enroll or make changes to your benefit elections.

Select the button on the screen to access a PDF copy of the Enrollment Action Checklist.

Benefits – Health

You have the option to choose from one of four health plans administered by either Highmark Delaware or Aetna. Let's first look at the plans administered by Highmark Delaware. These plans include the First State Basic PPO Plan and the Comprehensive Preferred Provider Organization (PPO) Plan. Both plans are a PPO Plan meaning that there is both in-network and out-of-network coverage and the plans also have plan year deductibles. For example, the First State Basic PPO Plan in-network services have a deductible of $500 per individual and $1,000 per family and then the plan will pay at 90% of the Highmark Delaware allowable charge.

The Comprehensive Preferred Provider Organization (PPO) Plan also has in- and out-of-network coverage. However, by using in-network services, you will pay only a small copay or coinsurance with no

deductible. More than 98% of services State of Delaware members seek are in-network, but you have the added benefit of out-of-network services, if needed, subject to a plan year deductible.

Learn more about what the Highmark Delaware plans cover and what the costs are, by visiting the SBO website. Select "Benefit Programs," choose "Health" then select "Highmark Delaware." To determine the monthly premium for each of the health plans, refer to the rate sheet for the upcoming plan year. You can view the Summary of Benefits and Coverage (SBC) for the First State Basic PPO Plan and the Comprehensive PPO Plan. On this link, you can also access Highmark Delaware's website, find a health provider and more.

Let's now look at the plans administered by Aetna. These plans include the Aetna CDH Gold Plan with an HRA and the HMO Plan. The Aetna Consumer Directed Health (CDH) Gold Plan with a Health Reimbursement Account (HRA) is a PPO Plan with an in-network plan year deductible of $1,500 per individual and $3,000 per family. The HRA is a fund of $1,250 per individual and $2,500 per family to help cover your eligible health expenses. Here is how it works - each year, the State funds the health reimbursement account - the fund - for you so that you can use the fund dollars to pay eligible out-of-pocket health care costs including the costs for services you receive before you satisfy the deductible. This means that you have less to pay out of your own pocket. Once you satisfy your in-network deductible, your health plan pays at 90% of the Aetna allowable charge. If you don't use the all of your fund dollars in one year, unused amounts will roll over to the next plan year as long as you remain in the CDH Gold Plan.

The Aetna HMO Plan is an in-network only plan but it includes both a local and broader national network so it is important to make sure the doctors and hospitals you use can accept the Aetna HMO coverage before you enroll. There is no out-of-network coverage under this plan which means that you will be 100% responsible for the cost of any services you receive from a provider or hospital that is not in the Aetna HMO network. Members in this plan are also required to select a Primary Care Physician (PCP) upon enrollment. Members who do not select a PCP upon enrollment will be automatically assigned one by Aetna. Members can find PCPs and provider numbers by using Aetna's Doc Find website. Members always have the flexibility to change their PCP at any time by simply contacting Aetna. Choosing a PCP is essential as your PCP will assist in managing and coordinating your care. Referrals are required for most services and are obtained through your PCP.

Learn more about what the Aetna plans cover and what the costs are, by visiting the SBO website. Select "Benefit Programs," choose "Health" then select "Aetna." To determine the monthly premium for each of the health plans, refer to the rate sheet for the upcoming plan year. You can view the Summary of Benefits and Coverage (SBC) for the HMO Plan and CDH Gold Plan. Check out the FAQs to learn how the CDH Gold Plan works. You can also access Aetna's website and mobile app, find a health provider using Doc Find as well as view Aetna's PCP Referral Chart to see how the HMO referral process works and more.

It is also important to note that most preventive care is covered at 100% for all health plans. The list of preventive services covered by Highmark Delaware or Aetna can be found by selecting "Dela*WELL* Health Management," then "Preventive Care."

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Benefits – Prescription

When you enroll in a State of Delaware health care plan, you are automatically enrolled in the prescription drug plan managed by Express Scripts. **The Spousal Coordination of Benefits (SCOB) policy also applies to prescription coverage.**

The State of Delaware list of covered medications (also known as the formulary) contains guidelines that can assist you with managing your prescriptions, identifying generics and choosing the most effective medications at the most reasonable price. Please note the formulary may change periodically as Express Scripts reviews and updates the plan's list of covered medications each year.

The amount you pay as your share of the cost for a prescription drug will vary depending on the specific medication and the number of days prescribed. The copayment is different for Tier 1 Generic, Tier 2 Preferred and Tier 3 Non-preferred drugs.

Generic drugs are approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Your Express Scripts plan includes a Generic vs. Brand Medications Choice Program, which allows you to purchase a brand medication when a generic equivalent is available. However, you will pay the generic copay plus the cost difference between the generic and the brand medication.

If there is a medical reason why you cannot take the generic equivalent, you, your doctor or your pharmacist may initiate a coverage review to allow you to obtain the brand-name drug at the non-preferred copay. These authorizations are effective for a one year period, and must be submitted for renewal annually.

The Express Scripts Prescription plan includes several member cost saving programs such as:

The **Maintenance Medication Program**, under which members fill 90-day prescriptions for maintenance medications for only two times the 30-day retail copayment. All 90-day prescriptions for non-specialty maintenance medications can be filled at any participating retail pharmacy or through Express Scripts Home Delivery. **Please note**: (1) You are required to fill certain long-term medications using 90-day fills or you will pay a penalty copay (see the Maintenance Medication Program information for more details). (2) Not all medications are available in a 90-day supply.

Under the **Preventive Medication & Services** program, members may receive certain preventive medications at no cost through the Express Scripts prescription drug plan, subject to age and other limitations. To obtain these preventive medications at no cost, the member must present a doctor's prescription for the medication to a participating Express Scripts pharmacy, even if the medication is available over the counter (OTC).

Under the **Diabetic Program**, members may obtain diabetic supplies (lancets, test strips, syringes/needles) at a participating retail pharmacy, a 90-day participating retail pharmacy, or through the Express Scripts Pharmacy (mail order) at no cost. Multiple prescriptions for diabetic medications provided via Express Scripts at a 90-day participating retail pharmacy or the Express Scripts Pharmacy and *purchased at the same time* may be obtained for one copay.

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Did you know that you can choose **Retail or Home Delivery**? Members may fill prescriptions for up to a 90-day supply of medication at any 90-day participating retail pharmacy or through Express Scripts Home Delivery, via the Express Scripts Pharmacy. Shipping is free and you can request refills by phone or online at Express-Scripts.com. To get started, mail the prescription, a completed mail-order form, and payment to Express Scripts Pharmacy, or ask your doctor to fax the prescription to Express Scripts Pharmacy by calling 1-888-327-9791 for instructions.

The **Coverage Review Programs** ensure you are receiving prescription medications that result in appropriate, cost-effective care. Examples include Step Therapy where certain medications may not be covered unless you have first tried another medication or therapy; Preferred Specialty Management which uses prior authorization and step therapy to ensure that you are taking the most clinically appropriate, cost-effective medication first; and quantity rules that are in place for several medications including narcotics and other controlled substances to comply with Federal Food and Drug Administration guidelines. In these examples, Express Scripts will need to review additional information from your doctor before a decision is made if the prescription medication can be filled under your plan.

For more information, contact Express Scripts Customer Service 24 hours a day, 7 days a week, toll-free at-1-800-939-2142. Pharmacists are available around the clock.
More detailed Express Scripts Prescription Drug Plan information can be found online on the SBO website. Select "Benefit Programs," choose "Prescription," then choose "Non-Medicare Prescription Plan." The Prescription Drug Plan Frequently Asked Questions (FAQ) provides answers to the most commonly asked questions about the Express Scripts Prescription Drug Plan.

Benefits – Dela*WELL* Health Management Program

All of your health and wellness programs, services and information come from one source - your trusted health plan carrier! Enrolling in a State of Delaware Group Health Plan provided by Highmark Delaware or Aetna gives you free, automatic, confidential access to their online resources, a 24/7 nurse line, health coaching, online health assessments and disease management/care coordination programs. A licensed professional Health Care Advisor (or Health Coach) may call if you have a health condition to offer you services to better manage your health. You are encouraged to take the call as what you learn could make a real difference in improving your health and quality of life.

The greatest wealth is having your health! The State of Delaware encourages you to focus on the things that really matter like leading a happy and healthy life. In addition, participation in the Dela*WELL* Health Management Program is an effective way to help manage long-term health care costs for you and for the State of Delaware.

The State of Delaware is encouraging members who are enrolled in either a non-Medicare Highmark Delaware Plan or Aetna Plan to complete these two simple steps:

1. Schedule and attend your Annual Physical Exam - Most preventive care is covered 100% (no charge to you). Your doctor (Internal Medicine, General Practitioners, Family Practice and GYNs) can provide annual physicals, as well as identify and treat small problems before they become serious. During a routine physical, your doctor can measure things like your height, weight and blood pressure, review your health history and make sure you are up to date with your age-appropriate screenings. A regular exam is a great way to help strengthen your doctor-patient relationship.

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2. Complete your online Health Assessment (Wellness Profile) - It is a simple online survey, located on the Highmark Delaware and Aetna websites, which helps you understand where you stand with your health and provides an action plan and recommendations that can help you to maintain or improve your well-being. When completing your online Health Assessment, be sure to have your latest biometric numbers handy from your annual physical exam, as it will ask for this information.

For additional information on the Dela*WELL* Health Management Program and the services and programs offered through Highmark Delaware and Aetna, visit the SBO website. Select "Benefit Programs," then choose "Dela*WELL* Health Management." Here you will find information on gym and wellness discounts, smart consumerism and the wellness and disease management/care coordination benefits provided through the health plan carriers.

Benefits – Dental

Delta Dental and Dominion National administer the State's dental programs. It is important to note that enrollment in these plans is a binding election. This means the contract holder cannot terminate their dental enrollment outside of Open Enrollment. The only changes permitted are to add or drop coverage for a dependent based on certain qualifying events during the plan year.

The Delta Dental PPO Plus Premier Plan allows you to see any dentist you choose and receive applicable benefits. You can choose a dentist from the Delta Dental Premier network, the Delta Dental PPO network or a dentist who does not participate with Delta Dental. However, you'll maximize your savings if you see a dentist who participates with Delta Dental. This is because dentists who participate in Delta Dental's network cannot charge you more than the allowed amount for covered services. However, non-participating dentists can bill you for an amount that is greater than the allowed amount set by Delta Dental for covered services. If a non-participating dentist charges more than the allowed amount, you are responsible for paying the difference. Delta Dental payments vary by service, based on Delta Dental's schedule of allowed amounts for its networks. Your annual reimbursement maximum is $1,500 per plan year per participant. Additional information about the Delta Dental Plan can be found on the SBO website. Select "Benefit Programs," choose "Dental," then select "Delta Dental." On this page, you can access benefit descriptions, rates and find a provider.

The Dominion National plan provides you the choice of any participating dentist in the Select Plan network. If you choose to enroll in the Dominion National plan make sure *before* you enroll that your dentist participates in the Select Plan network by viewing the provider listing found on the Dominion National website. You cannot change plans or drop coverage during the plan year if your dentist decides to no longer participate in the plan. If your dentist decides to no longer participate in the plan, your only option is to select a different dentist from the provider listing.

The Dominion National plan provides limited costs, fixed fees and low premiums. It is important to note that you will need to pay a $10 office visit copayment for your cleaning at the time of service. But, for each member who gets their two cleanings during the plan year and completes a survey, Dominion National will reimburse you $20. Additional information about the Dominion National Plan can be found on the SBO website. Select "Benefit Programs," choose "Dental," then select "Dominion National." On this page, you can access benefit descriptions, rates and find a provider.

Please note: School district employees who are offered school district dental coverage are not eligible to enroll under the State's Dental Plan. Delaware Technical and Community College (DTCC) employees have the option of enrolling in both the State's dental and/or the DTCC dental plan. Employees should

contact their Human Resources/Benefits Office for more information regarding their dental options.

Benefits – Vision

EyeMed administers the State's vision program. EyeMed provides a network of participating providers for State of Delaware members. This network is called Insight. Members have the flexibility to use in-network or out-of-network providers; however, choosing in-network providers will give members the best value and pay a higher amount of the cost of services covered under this benefit.

The benefits under the State of Delaware's EyeMed program include coverage for exams with dilation as necessary, frames, lenses or contact lenses and much more.

Did you know that the vision program also offers benefits for vision therapy, diabetic eye care, discounts on laser vision correction and additional savings? Members have the opportunity to apply their contact lens benefits at ContactsDirect.com. Members can also apply their in-network vision benefits at Glasses.com.

The State's vision program also offers discounts on hearing exams, hearing aids, free batteries for two years with initial purchase and a three year warranty.
The vision enrollment is a binding election. This means the contract holder cannot terminate their vision enrollment outside of Open Enrollment. The only changes permitted are to add or drop coverage for a dependent based on certain qualifying events during the plan year. All the information you need to know about the Vision plan, including benefit descriptions, rates and discounts, is located on the SBO website. Select "Benefit Programs," then choose "Vision."

Participants should contact the COBRA administrator regarding their vision benefit options under COBRA.

Benefits – Employee Assistance Program (EAP) + Work/Life

The experts at your confidential EAP+Work/Life program, administered by Health Advocate can find resources to help you get more balance in your life. Health Advocate is available seven days a week, 24 hours a day to meet all of your needs.

Work/Life:

- Balancing Work & Family
- Time Management
- Working with Others
- Occupational Stress
- Career Development
- Workplace Safety/Productivity

Personal Well-Being:

- Anxiety; Depression; Substance Abuse
- Relationships; Family/Parenting
- Stress Management; Grief and Loss

Living Resources:

- Financial Help; Legal Assistance

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- Childcare; Adult Care

The EAP+Work/Life program is available exclusively for State of Delaware Group Health Plan Members and their dependents, including parents and parents-in-law. Your EAP+Work/Life program, paid for by the State of Delaware, is completely confidential.

As part of your employee benefit plan, you have access to a wide range of EAP+Work/Life support services from Health Advocate, including Professional Counseling Services, Legal Services, Interactive Website and much more.

View additional information about the EAP+Work/Life Program, including contact information, benefit descriptions and helpful resources on the SBO website. Select "Benefit Programs," then choose "EAP+Work/Life."

Benefits – Blood Bank

Blood Bank of Delmarva is a 501(c)3 non-profit, community service program that provides blood and blood products for hospitals in the Delmarva region. More than 350 blood donors are needed every day to meet the needs of patients at those hospitals.
Each year, in our community, over 20,000 patients need blood or a blood product. By joining Blood Bank of Delmarva's Members for Life program, you are showing your support for this valuable community service and helping to ensure a stable blood supply for everyone in our community. Also, each time you give, you not only save lives, but you earn rewards and benefits.

Joining is easy! Donate blood at least once a year and allow the Blood Bank to contact you when there is a need for your blood type.

Individuals interested in participating in Members for Life can view information about the program, including contact information and benefit descriptions, on the SBO website. Select "Benefit Programs," then choose "Blood Bank."

Coordination of Benefits – Spousal

The Spousal Coordination of Benefits Policy states that generally, if your spouse is employed full-time or retired from another employer that offers health insurance and is responsible for 50 percent or less of the monthly premium for the lowest health benefit plan available, he or she is required to enroll through his or her employer's coverage as primary. When a benefit-eligible State of Delaware employee is married to a benefit-eligible Participating Group Employee, both members must enroll in separate coverage with his or her own employer. Neither member can be enrolled in more than one State Group Health Insurance Plan*.

If you cover your spouse in one of the State of Delaware's Group Health Insurance medical plans, you MUST complete a Spousal Coordination of Benefits form upon initial enrollment, each year during your Open Enrollment period and anytime your spouse's employment or insurance status changes. If an employee and spouse are both benefit-eligible State of Delaware employees or non-Medicare pensioners, the spouse who carries the benefits MUST complete a new Spousal Coordination of Benefits form each year during Open Enrollment. When completing the form, make sure to indicate in the Spouse Information section that your spouse is either a benefit-eligible State of Delaware employee or if a pensioner, that your spouse retired from the State of Delaware. If you are a pensioner and cover a spouse in the Highmark Delaware Special Medicfill Medicare Supplement plan, you DO NOT need to

complete a Spousal Coordination of Benefits Form, UNLESS your spouse's employment or retiree health insurance status has changed since the last time you completed a form.

The Spousal Coordination of Benefits Form is used to determine a spouse's eligibility to receive primary coverage in a State of Delaware Group Health Insurance plan and to certify if the spouse has other health care coverage available through his or her employer or former employer. You will be contacted if additional documentation regarding your spouse's available coverage is required. Failure to complete the Spousal Coordination of Benefits Form or provide additional documentation when required, will result in a reduction of spousal benefits.

Information about the Spousal Coordination of Benefits Policy can be found on the SBO website. Select "Coordination of Benefits," then choose "Spousal." Here you will find:

- The Spousal Coordination of Benefits Policy
- Information on accessing the Spousal Coordination of Benefits Electronic Form
- A chart with examples to help determine when a spouse should be enrolled in their own employer's health plan
- Important information if your spouse's employer offers a High Deductible Health Plan with a Health Savings Account

Coordination of Benefits – Dependent

The Dependent Coordination of Benefits Policy states Active State of Delaware employees, Participating Group employees and State pensioners enrolled in a health care plan under the State Group Health Insurance Program (GHIP), may cover their dependent children to age 26 in their State health care plan, dental plan and/or vision plan with no restriction on marital, employment, student, resident or tax status. Pursuant to the Group Health Insurance Program Eligibility and Enrollment Rules, an employee's children are defined as sons, daughters, stepchildren and adopted children.

The Dependent Coordination of Benefits Form is required in accordance with the Group Health Insurance Program Eligibility and Enrollment Rules. Dependent Coordination of Benefits forms must be completed for each enrolled dependent regardless of age, upon:

- Enrollment in other health coverage,
- Any time other health coverage changes, or
- Upon request by the Statewide Benefits Office, Highmark Delaware or Aetna

The Dependent Coordination of Benefits Form only needs to be completed for dependent children - not spouses. And, it does not need to be completed if your child only has coverage through the State GHIP.

Information about the Dependent Coordination of Benefits Policy can be found on the SBO website. Select "Coordination of Benefits," then choose "Dependent Child." Here you will find the Dependent Coordination of Benefits Policy and FAQs, the Dependent Coordination of Benefits Form for each carrier, and a helpful chart with examples showing which plan is primary (pays first) when a dependent child has more than one health care coverage.

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Policies

Important policies and procedures are located on the SBO website. Select the "Policies & Procedures" button.

Here you will find information on:

- Double State Share
- Spousal & Dependent Child Coordination of Benefits
- Qualifying Events
- And more…

If you have questions about the policies and procedures, please contact the Statewide Benefits Office at 1-800-489-8933 or benefits@state.de.us from 8:00 a.m. to 4:30 p.m. Monday through Friday.

Notices

Health care coverage notices and other important information are located on the SBO website. Select "Policies & Procedures," then choose "Group Health Insurance Program (GHIP) Notices."

These notices relate to the State of Delaware Group Health Insurance Program (also known as the GHIP) and are effective as of the date shown.
Questions regarding these notices can be addressed to the Statewide Benefits Office at 1-800-489-8933 from 8:00 a.m. to 4:30 p.m. Monday through Friday or at benefits@state.de.us or questions may be directed to the additional contacts identified in the various notices.

Health Fairs

Please plan to attend the health fairs if you are enrolled or are eligible to enroll in the State of Delaware Group Health Insurance Program (also known as the GHIP). Spouses and dependents who are enrolled or eligible to enroll in the GHIP are welcome to attend the health fairs.

The health fairs provide an opportunity for benefit-eligible individuals to explore the benefit vendor booths and learn more about their benefit options available through the State of Delaware. No registration is required.

Statewide Benefits Office Health Fairs are scheduled as follows:

NEW CASTLE COUNTY
Tuesday, May 8, 2018
Delaware Technical Community College (Stanton Campus)
400 Stanton-Christiana Road, Newark, DE 19713
Conference Rooms A114 & A116
Time: 11am-6pm

Tuesday, May 15, 2018
Carvel State Office Building
820 N. French Street, Wilmington, DE 19801
2nd Floor Mezzanine
Time: 10am-2pm

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KENT COUNTY
Tuesday, May 1, 2018
Delaware State University
1200 N. DuPont Highway, Dover, DE 19901
Martin Luther King Jr. Student Center
Parlors B & C (2nd Floor)
Time: 11am - 6pm

Monday, May 14, 2018
Duncan Center
500 W. Loockerman Street Dover, DE 19904
5th Floor - Outlook Conference Center
Time: 11am - 6pm

SUSSEX COUNTY
Wednesday, May 9, 2018
Delaware Technical Community College (Owens Campus)
21179 College Drive Georgetown, DE 19947
William A. Carter Partnership Center
Rooms 540 A-H
Time: 10am-2pm